Definition and Practice of Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action. This includes, but is not limited to, review of treatment plan and progress notes, client specific case discussion, periodic assessments of the client (as defined in each section), and diagnosis, treatment intervention or issue specific discussion. The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment team. The critical involvement of the supervising practitioner must be reflected in the ~~pre-treatment assessment~~ Initial Diagnostic Interview, the treatment plan, and the interventions provided.

The supervising practitioner (or their designated and qualified substitute) must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.

Supervisory contact may occur in a group setting.

Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.

Psychiatric resident physicians, physician assistants and Advanced Practice Registered Nurses may not supervise allied health therapists for ~~NMAP~~ Medicaid services.

Effective December 1, 2008, Licensed Independent Mental Health Practitioners may supervise other licensed practitioners.

The supervising practitioner shall periodically evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed.

2. Psychiatrically trained physician extenders may not supervise services in place of the physician, but may provide direct care as allowed by the scope of practice guidelines set by the Nebraska Department of Health and Human Services, Division of Public Health and the practice agreement of each individual. A copy of the practice agreement must be submitted at the time of application for enrollment.
3. Licensed Independent Mental Health Practitioners (LIMHP) may provide direct care as allowed by the scope of practice guidelines set by Nebraska Department of Health and Human Services, Division of Public Health.
4. Allied Health Therapists: All psychotherapy services provided by allied health therapists must be prescribed by the supervising practitioner and provided under his/her supervision. All allied health therapists must have knowledge of the interactional systems within families.
   Allied health therapists include:
   a. Specially Licensed Psychologists: Persons who are specially licensed as psychologists through the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;
   b. Licensed Mental Health Practitioners: Persons who are licensed as mental health practitioners by the Nebraska Department of Health and Human Services, Division of Public Health or the appropriate licensing agency of the state in which s/he practices;

20-001.17 Treatment Plans: A treatment plan must be established for each client. The treatment plan is a comprehensive plan of care formulated by the clinical staff under the direction of a supervising practitioner and is based on the individual needs of the client. The treatment plan validates the necessity and appropriateness of services and outlines the service delivery needed to meet the identified needs, reduce problem behaviors, and improve overall functioning.

The treatment plan must be based upon an assessment of the client's problems and needs in the areas of emotional, behavioral, and skills development. The treatment plan must be individualized to the client and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the client's progress; and the responsible professional.

The goals and objectives documented on the treatment plan must reflect the recommendations ~~included in the Pre-treatment Assessment and the integration of input~~ from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

A treatment plan must be developed for every client within the time frames specified for each type of service and must be placed in the client's clinical record. If a treatment plan is not developed within the specified time frames, services rendered may not be ~~NMAP~~ Medicaid reimbursable.

The treatment plan must be reviewed and updated by the treatment team according to the client's level of functioning. Minimum time frames for treatment plan reviews are dependent on the type of service. Refer to each individual service description for the review requirements. The purpose of this review is to ensure that services and treatment goals continue to be appropriate to the client's current needs, and to assess the client's progress and continued need for psychiatric services. The supervising practitioner and treatment team members shall sign and date the treatment plan at each treatment plan review.

If the client is receiving services from more than one psychiatric provider, these agencies must coordinate their services and develop one overall treatment plan for the client or family. This treatment plan is used by all providers working with the client or family.

At the facility's or provider's request, copies of the facility's or provider's response will be sent to all parties who received a copy of the inspection report in 471 NAC 20-001.20H.

A return site visit may occur after the written response is received to determine if changes have completely addressed the review team's concerns from the IOC report.

The Department will take appropriate action based on confirmed documentation on inaccuracies.

20-001.20K Department Action on Reports: The Department will take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

20-001.20L Appeals: See 471 NAC 2-003 ff. and 465 NAC 2-001.02 ff. and 2-006 ff.

20-001.20M Failure to Respond: If the facility or provider fails to submit a timely and/or appropriate response, the Department may take administrative sanctions (see 471 NAC 2-002 ff.) or may suspend ~~NMAP~~ Medicaid payment for an individual client or the entire payment to the facility or provider.

20-001.21 Procedure Codes: Providers shall use HCPCS/CPT procedure codes when submitting claims to the Department for Medicaid services. Procedure codes used by ~~NMAP~~ Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

20-001.22 ~~Pre-Treatment Assessment (Biopsychosocial Assessment and~~ Initial Diagnostic Interview~~)~~: For services in this chapter to be covered by ~~NMAP~~ Medicaid, the necessity of the service for the client shall be established through ~~a pre-treatment assessment~~.an Initial Diagnostic Interview. For services in this chapter to be covered by ~~NMAP~~ Medicaid, the client must have a diagnosable mental health disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistics Manual of the American Psychiatric Association that results in functional impairment which substantially interferes with or limits the person's role or functioning within the family, job, school, or community. This does not include V-codes or developmental disorders.

~~This assessment~~ The Initial Diagnostic Interview is used to identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the client. This comprehensive plan of care will be outlined in the individualized treatment plan and should reflect an understanding of how the individual's particular issues will be addressed with the service. The ~~assessment~~ Initial Diagnostic Interview must occur prior to the initiation of treatment interventions and must include a baseline of the client's current functioning and treatment needs. EXCEPTION: Clients receiving acute inpatient hospital services are not required to receive ~~a pre-treatment evaluation~~ an Initial Diagnostic Interview before services are initiated. Providers of the acute services must facilitate or perform the ~~pre-treatment assessment~~ Initial Diagnostic Interview.

~~The biopsychosocial assessment must be completed by a staff person, acting within his/her scope of practice, who is enrolled as a provider of psychiatric services with the Department. The staff person is responsible for gathering the information included on the assessment through direct face-to-face interview, contact with the family and the comprehensive review of the client's past records.~~ The licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice must complete, ~~at a minimum~~, the Initial Diagnostic Interview within four weeks of the initial session with the therapist. ~~The recommendations must be developed by both practitioners and the practitioners must sign the assessment. Licensed Independent Mental Health Practitioners practicing under their scope of practice must provide both the comprehensive mental health assessment which must include all of the components of the Biopsychosocial assessment and the Initial Diagnostic Interview (see the fee schedule for the appropriate code and modifier). The assessment must include, to the degree deemed clinically appropriate by the qualified mental health professional, but is not limited to the following information:~~

~~Biopsychosocial Assessment~~

~~1. Presenting Problem and Goals as Described by:~~
~~a. Client;~~
~~b. Family;~~
~~c. Others;~~
~~2. Social History:~~
~~a. Environmental influences (moves and reasons, housing conditions);~~
~~3. Family Dynamics:~~
~~a. Demographic and historical information;~~
~~b. Divorces, separations, deaths, and incarcerations of parents/ client and significant others (include reasons);~~
~~c. Client and family vocational history;~~
~~d. Client and family treatment history;~~
~~4. Mental Health History:~~
~~a. Symptoms;~~
~~b. Diagnoses;~~
~~c. Treatment interventions including psychotropic medications (outcome);~~
~~5. Academic, Intellectual, and Vocational History:~~
~~a. Academic history;~~
~~b. Most recent IQ and historical;~~
~~c. Learning disabilities, behavior disorders, or impairment;~~
~~d. Interventions and outcomes;~~
~~e. Vocational history or training;~~

~~6. Medical History:~~
~~a. Physical development;~~
~~b. Prenatal, birth, development milestones;~~
~~c. History of injuries and illnesses, handicapping conditions;~~
~~d. Chronic medical conditions and medications taken;~~
~~e. Sexual development, menstrual history, pregnancies, births, or fathered children;~~
~~7. Legal History:~~
~~a. Offenses against the client;~~
~~b. History and current legal status;~~
~~8. Offender Issues;~~
~~a. Incarceration or probation;~~
~~b. Violence to property;~~
~~c. Violence and assault to others;~~
~~d. Other;~~
~~9. Victim Issue:~~
~~a. Physical Abuse;~~
~~b. Sexual Abuse;~~
~~c. Emotional Abuse;~~
~~d. Neglect;~~
~~e. Other;~~
~~10. Substance Abuse History;~~
~~a. Client use;~~
~~b. Family history;~~
~~c. Treatment history; and~~
~~11. Personal Assets and Liabilities.~~

Initial Diagnostic Interview

1. Psychiatric Evaluation with relevant client information, mental status exam and diagnosis;
2. Recommendations:
   a. Treatment needs and recommended interventions for client and family;
   b. Identification of who needs to be involved in the client's treatment;
   c. Overall plan to meet the treatment needs of the client including transitioning to lower levels of care and discharge planning;
   d. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge;
   e. Recommended linkages with other community resources;
   f. Other areas that may need further evaluation.

~~Pre-treatment assessments that are incomplete or do not include the initial diagnostic assessment~~ Initial Diagnostic Interviews that are incomplete will not be reimbursable.

20-001.22A Involvement of the Supervising Practitioner: The supervising practitioner ~~(see 471 NAC 20-001.13, #1)~~ must meet face to face with the client to complete ~~at a minimum,~~ the Initial Diagnostic Interview. ~~as part of the pre-treatment assessment~~. The supervising practitioner must work with the staff person to develop the recommendations. The supervising practitioner must sign the assessment document.

20-001.22B Payment for ~~Pre-treatment Assessments~~ Initial Diagnostic Interview : Payment for ~~pre-treatment assessments~~ the Initial Diagnostic Interview outlined in the previous section is made according to the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532). Practitioners shall use the national code sets to bill ~~for pre-treatment assessment functions provided by the clinical staff person and~~ for the Initial Diagnostic Interview. ~~provided by the supervising practitioner.~~ The reimbursement for these codes includes interview time, documentation review, and the writing of the report and recommendations.

~~The assessment must address each area listed in this section to be eligible for reimbursement~~.

Providers of the ~~pre-treatment assessment~~ Initial Diagnostic Interview shall bill ~~for the entire assessment (Biopsychosocial Assessment and Initial Diagnostic Interview) at one time and~~ on claim form CMS-1500 or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). The completed ~~Pre-Treatment Assessment~~ Initial Diagnostic Interview must be included in the client file and available for review upon request. Failure to produce documentation of an Initial Diagnostic Interview ~~a completed pre-treatment assessment~~ upon request, or lack of inclusion in the client file determined during review, shall be cause for claim denial and/or refund.

~~NMAP~~ Medicaid will provide reimbursement for one ~~pre-treatment assessment~~ Initial Diagnostic Interview per treatment episode. Addendums may be included if additional information becomes available. If the client remains involved continuously in treatment for more than one year, reimbursement for ~~a pre-treatment assessment~~ an Initial Diagnostic Interview may ~~will~~ be available annually. If the client leaves treatment prior to a successful discharge and returns for further treatment, the provider must assess the need for an addendum or a new ~~assessment~~ Initial Diagnostic Interview. A second ~~pre-treatment assessment~~ Initial Diagnostic Interview within a year must be prior authorized. Practitioners shall use national code sets to bill for this activity. ~~Prior authorization is obtained through the Division of Medicaid and Long-Term Care or their designee~~.

For further instructions on billing for outpatient mental health and substance abuse services, please see 471 NAC 20-002.12.

20-001.22C Procedure Codes and Descriptions for ~~Pre-Treatment Assessments~~: Initial Diagnostic Interviews: HCPCS/CPT procedure codes used by ~~NMAP~~ Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

20-001.22D Distribution of the ~~Pre-Treatment Assessment~~: Initial Diagnostic Interview: Providers must distribute complete copies of the ~~pre-treatment assessment~~ Initial Diagnostic Interview to other treatment providers in a timely manner when the information is necessary for a referral and the appropriate releases of information are secured.

20-002.04A Services Provided by Allied Health Therapists: Services provided by Allied Health Therapists (as defined in 471 NAC 20-001.13) must be prescribed and provided under the direction of a supervising practitioner. Supervision must meet the active treatment criteria in 471 NAC 20-001.16.

Definition and Practice of Supervision: Supervision by the supervising practitioner is defined as the critical oversight of a treatment activity or course of action. This includes, but is not limited to, review of treatment plan and progress notes, client specific case discussion, periodic assessments of the client (annually, or more often if necessary), and diagnosis, treatment intervention or issue specific discussion. The supervising practitioner is a source of information and guidance for all members of the treatment team and their participation in services as an essential ingredient for all members of the treatment. The critical involvement of the supervising practitioner must be reflected in the ~~pre-treatment assessment~~ Initial Diagnostic Interview, the treatment plan, and the interventions provided.

The supervising practitioner (or their designated and qualified substitute) must be available, in person or by telephone, to provide assistance and direction as needed during the time the services are being provided.

Supervisory contact may occur in a group setting.

Supervision is not billable by either the therapist or the supervising practitioner as it is considered a mandatory component of the care.

Psychiatric resident physicians and physician extenders may not supervise allied health therapists for ~~NMAP~~ Medicaid services.

The supervising practitioner shall periodically evaluate the therapeutic program and determine if treatment goals are being met and if changes in direction or emphasis are needed.

The supervising practitioner must personally re-evaluate the client through a face-to-face contact annually or more often, if necessary.

20-002.05 ~~Pre-Treatment Assessment~~: Initial Diagnostic Interview: Before a client is accepted for treatment, ~~a pre-treatment assessment~~ an Initial Diagnostic Interview must be completed ~~(see 471 NAC 20-001.02)~~.

The supervising practitioner must evaluate the client within four weeks of the initial contact with the therapist, or sooner if necessary. If the client does not continue with therapy sessions past the fourth session or does not attend the assessment session ~~on~~ with the supervising practitioner, the therapist must review the specific case with the supervising practitioner, to establish a diagnosis and confirm that the interventions were appropriate. For clients continuing in therapy, reimbursement will not be available for more than four sessions until the client is assessed by the supervising practitioner.

20-002.06 Treatment Planning: When treatment is initiated, the provider shall work with the client and family (at the client's discretion) to develop ~~complete the Department's approved treatment planning document to document~~ the treatment plan. If the client is accepted for treatment, the treatment plan must be completed within two sessions of the assessment by the supervising practitioner and is based on the following:

1. The client must have sufficient need for active psychiatric treatment at the time the psychiatric service provider accepts the client; and
2. The treatment must be the best choice for expecting reasonable improvement in the client's psychiatric condition.

The goals and objectives documented on the treatment plan must reflect the recommendations ~~included in the Pre-treatment Assessment and the integration of input~~ from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

20-002.06A ~~Department's Approved~~ Treatment Planning Document Update: The treatment plan must be reviewed and updated every 90 days, or more frequently if indicated. The client's clinical record must include the supervising practitioner's comments on the client's response to treatment and changes in the treatment plan. The supervising practitioner must review and sign off on the updated treatment plan prior to its initiation. Changes in the treatment plan must be noted on the current ~~Department approved~~ treatment planning document. In addition, the psychiatric service provider shall complete an updated ~~Department approved~~ treatment planning document annually, or more frequently if necessary, to reflect changes in treatment needs. A copy of the current ~~Department approved~~ treatment planning document must be maintained in the client's medical record. ~~All fields on the Department's approved treatment planning document must be completed.~~

For services provided under the supervision of a supervising practitioner, the signature of the supervising practitioner on the ~~Department approved~~ treatment planning document indicates his/her agreement that the scheduled treatment interventions are appropriate.

20-002.07 Documentation in Client's Clinical Records: All documents submitted to ~~NMAP~~ Medicaid must contain sufficient information for identification (i.e., client's name, dates, and time of service, provider's name). Documentation must be legible. The client's medical record must also include -

1. ~~The pre-treatment assessment~~; The Initial Diagnostic Interview.
2. ~~The Department's approved treatment planning document~~ The treatment plan, (including the initial document, updates, and current);
3. The client's diagnosis. A provisional or interim psychiatric diagnosis must be established by the supervising practitioner at the time the client is accepted for treatment. This diagnosis must be reviewed and revised as a part of the ~~Department's approved treatment planning document;~~ treatment plan;
4. A chronological record of all psychiatric services provided to the client, the date performed, the duration of the session, and the staff member who conducted the session;
5. A chronological account of all medications prescribed, the name, dosage, and frequency to be administered and client's response;
6. A comprehensive family assessment.
7. A clear record of family and community involvement;
8. Documentation verifying coordination with other therapists when more than one provider is involved with the client/family; and
9. Transition/discharge planning.

20-002.08 Transition/Discharge Planning Services: Providers of outpatient psychiatric services shall meet the transition/discharge planning requirements noted in 471 NAC 20-001.18.

20-002.09 Utilization Review: Payment for outpatient psychiatric services is based on adequate legible documentation of medical necessity and active treatment. All outpatient claims ~~received by the Department~~ are subject to utilization review ~~by the Department~~ before payment. Illegible documentation may result in denial of payment (see 471 NAC 20-001.19).

Additional documentation from the client's clinical record may be requested ~~by the Department~~ prior to considering authorization of payment when the ~~Department's approved~~ treatment plan ~~planning document~~ does not adequately document medical necessity or active treatment.

20-002.10 Guidelines for Specific Services

20-002.10A Psychological Testing and Evaluation Services: Testing and evaluation services must reasonably be expected to contribute to the diagnosis and plan of care established for the individual client. Medical necessity must be documented.

Testing and evaluation services may be performed by a licensed psychologist, or by a specially licensed psychologist or a master's level person approved to administer psychological testing under the supervision of a licensed psychologist.

If testing and evaluation services are provided by a licensed, non-certified psychologist, the services must be ordered by a supervising practitioner. The treatment plan must be signed by the supervising practitioner.

A copy of the testing narrative summary must be kept in the client's clinical record. If the evaluation is court ordered, the provider shall note this on the treatment plan and include documentation of medical need for the service. Payment is made according to the Nebraska Medicaid Practitioner Fee Schedule.

20-002.10B Grandparented Masters Psychologists: Services provided by master's level clinical psychologists whose certification has been grandparented by the Department of Health and Human Services, Division of Public Health may be covered under 471 NAC 20-002 ff. Documentation of the grandparented status may be required.

20-002.10C Medication Checks: Medication checks may only be done when medically necessary. When a physician provides psychotherapy services, medication checks are considered a part of the psychotherapy service.

The supervising physician may provide a medication check when a licensed psychologist or an allied health therapist provides the psychotherapy service. Only physicians and psychiatrically trained physician extenders may provide medication checks.

7. Pre-Admission Evaluation: ~~The need for this level of care must be recommended on the pre-treatment assessment or addendum~~. Before the client is admitted to the program, the supervising practitioner shall complete an Initial Diagnostic Interview to validate the appropriateness of care. When a client is transferred from inpatient hospital care to day treatment, the inpatient evaluation and discharge summary documenting the rationale of transfer as part of the treatment plan serves the same purpose as the Initial Diagnostic Interview. The evaluation must be filed in the client's medical record. The pre-admission evaluation must include -
   a. A clinical assessment of the health status and related psychological, medical, social, and educational needs of the client; and
   b. A determination of the range and kind of services required.

   The supervising practitioner shall personally complete an Initial Diagnostic Interview which must be used to develop the plan of care if all admission criteria have been met;
8. Treatment Plan: The program supervising practitioner shall determine the psychiatric diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.

   The goals and objectives documented on the treatment plan must reflect the recommendations ~~included in the Pre-treatment Assessment and the integration of input~~ from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

   The treatment plan shall be completed upon the client's admission to the program;
9. At least every 30 days thereafter, a treatment plan review must be conducted by the multi-disciplinary team, including the supervising practitioner. The treatment plan reviews must be documented. ~~on the Department approved treatment planning document (if required), and in the treatment plan. The facility's treatment plan review format, if approved by the Department, may function as the Department approved treatment planning document.~~

   The ~~Department approved treatment planning document~~ treatment plan must be signed by the program supervising practitioner for day treatment services;
10. The supervising practitioner must personally evaluate the client every 30 days, or more often, as medically necessary. This evaluation must occur in a one-to-one, face-to-face session separate from the treatment plan review;

11. Every 30 days a utilization review must be conducted per 471 NAC 20-003.07. This review must be documented on the ~~Department approved treatment planning document (if required) and the facility's~~ treatment plan. ~~review form~~. Utilization review is not required for the calendar month in which the client was admitted;
12. The program must have a description of each of the services and treatment modalities available. This includes psychotherapy services, nursing services, psychological diagnostic services, pharmaceutical services, dietary services, and other psychiatric day treatment services.
    a. The program must have a description of how the family-centered requirement in 471 NAC 20-001 will be met, including a complete description of any family assessment and family psychotherapy services.

       Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

       Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

       The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends;
    b. The program must have a description of how the community-based requirement in 471 NAC 20-001 will be met;
    c. The program shall state the qualifications, education, and experience of each staff member and the therapy services each provides.;
    d. The program must have a daily schedule covering the total number of hours the program operates per day. The schedule must be submitted to the Department for approval. The program must be fully staffed and supervised during the time the program is available for services, and must provide at least three hours of approved treatment for each day services are provided. This schedule must be updated annually, or more frequently if appropriate;

20-003.04 Coverage Criteria for Day Treatment Psychiatric Services: The Nebraska Medical Assistance Program covers psychiatric day treatment services for clients 21 and over when the services meet the requirements in 471 NAC 20-001.

The client must be observed and interviewed by the program supervising practitioner at least every 30 days or more frequently if medically necessary and the interaction must be documented in the client's medical record.

20-003.04A Services Not Covered Under ~~NMAP~~: Medicaid: Payment is not available for psychiatric day treatment services for clients -

1. Receiving services in an out-of-state facility, except as outlined in 471 NAC 1-002, Services Provided Outside Nebraska;
2. Living in long term care facilities or Institutes for Mental Disease;
3. Whose needs are social or educational and may be met through a less structured program;
4. Whose primary diagnosis and functional impairment is psychiatric in nature but is not stable enough to allow them to participate in and benefit from the program; or
5. Whose behavior may be very disruptive and/or harmful to other program participants or staff members.

20-003.05 Documentation in the Client's Clinical Record: All documents submitted to ~~NMAP~~ Medicaid must contain sufficient information for identification (i.e., client's name, dates of service, provider's name) and must be legible. Each client's clinical record must contain the following documentation:

1. The supervising practitioner's orders;
~~2.~~ ~~The pre-treatment assessment~~;
2. The Initial Diagnostic Interview and referral documented by the supervising practitioner;
3. The treatment plan ~~planning document (or a facility treatment plan, if applicable);~~
~~5.~~4. The team progress notes, recorded chronologically. The frequency is determined by the client's condition, but the team's progress notes must be recorded at least weekly. The progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan, as indicated by the client's condition, and discharge planning;
~~6.~~5. Documentation indicating compliance with all requirements in 471 NAC 20-001;
~~7.~~6. The program's utilization review committee's abstract or summary; and
~~8.~~7. The discharge summary.

20-003.06 Transition and Discharge Planning: Each provider must meet the 471 NAC 20-001 requirements for transition and discharge planning.

20-003.09 Record Retention: The provider shall retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period. The Department shall retain all cost reports for at leave five years after receipt from the provider.

20-003.10 Billing Requirements: For day treatment services, the following requirements must be met:

1. Providers of non-hospital based day treatment services shall submit claims for day treatment services on an appropriately completed Form CMS-1500 (see 471-000-64) or the standard electronic Health Care Claim: Professional transaction (ASC X12N 837).

   Payment for approved day treatment services is made to the facility.

2. Providers of hospital based day treatment services shall submit claims for services on an appropriately completed Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837).

   Payment for approved hospital based day treatment services is made to the hospital.

20-003.10A Documentation for Claims: The following documentation, kept in the client's file, is required for all claims for day treatment services:

1. ~~Pre-treatment assessment;~~ Initial Diagnostic Interview
2. Supervising practitioner orders;
3. ~~A complete family assessment;~~
4 3. Nurses' notes; and
5 4. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment. Reimbursement may be denied if claims and/or documentation are illegible (see 471 NAC 20-001.19).

20-003.10B Exception: Additional documentation from the client's medical record may be requested by the Department prior to considering authorization of payment. Progress notes for other Medicaid clients may be requested when the treatment report does not adequately explain family psychotherapy or medical necessity cannot be determined.

20-003.11 Procedure Codes and Descriptions for Psychiatric Day Treatment: HCPCS/CPT procedure codes used by ~~NMAP~~ Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-532).

20-006.03 Staffing Standards for Participation: Subacute inpatient psychiatric hospital must have staff adequate in number and qualified to carry out a subacute psychiatric program for treatment for individuals who are in need of further psychiatric stabilization, treatment, rehabilitation, and recovery activities. The hospital must meet the following standards.

1. Hospital Personnel: Hospitals that provide subacute inpatient psychiatric services must be staffed with the number of qualified professional, technical, and supporting personnel, and consultants required to carry out an intensive and comprehensive treatment program that includes evaluation of individual and family needs; establishment of individual and family treatment goals; and implementation, directly or by arrangement, of a broad-range psychiatric treatment program including, at least, professional psychiatric, medical, nursing, social services, psychological, psychotherapy, psychiatric rehabilitation, and recovery therapies required to carry out an individual treatment plan for each patient and their family. The following standards must be met:
   a. Qualified professional psychiatric staff must be available to evaluate each patient at the time of admission, including diagnosis of any intercurrent disease. Services necessary for the evaluation include:
      ~~(1) Biopsychosocial assessment by a multi-disciplinary team;~~
      (1) Initial Diagnostic Interview ~~Psychiatric diagnostic evaluation by the attending psychiatrist;~~
      (2) Nursing assessment by a licensed registered nurse;
      (3) Substance abuse assessment as appropriate;
      (4) Laboratory, radiological, and other diagnostic tests as necessary; and
      (5) A physical examination including a complete neurological examination when indicated within 24 hours after admission by a licensed physician.
   b. The number of qualified professional personnel and paraprofessionals, including licensed professional staff and technical and supporting personnel, must be adequate to ensure representation of the disciplines necessary to establish short-range and long-term goals; and to plan, carry out, and periodically revise a treatment plan for each client.
      (1) Qualified staff must be available to provide treatment intervention, social interaction and experiences, education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance abuse education, appropriate nursing interventions and structured milieu therapy. Available services must include individual, group, and family therapy, group living experiences, occupational and recreational therapy and other prescribed activities to maintain or increase the individual's capacity to manage his/her psychiatric condition and activities of daily living. A minimum of 42 structured, scheduled, and documented treatment hours are required per week.
      (2) The program must provide environmental and physical limitations required to protect the client's health and safety with a plan to develop the client's potential for return to his/her home, supervised adult living, or skilled nursing facility. The treatment milieu must be a safe, organized, structured environment at the least restrictive level of care to meet the individualized treatment needs of the client.

20-006.10 Prior Authorization Procedures: All subacute inpatient psychiatric admissions must be prior-authorized by the Department-contracted peer review organization or management designee. If the admission is approved, the Department-contracted peer review organization or management designee must assign a specific prior-authorization number. Providers must follow the Department-contracted peer review organization or management designee guidelines for facilitating prior authorization and continued stay review. Continued stay authorization is provided at a frequency appropriate for this short-term subacute program by the Department-contracted peer review organization or management designee.

20-006.11 Documentation in the Client's Clinical Record: The medical records maintained by a hospital permit determination of the degree and intensity of the treatment provided to clients who receive services in a subacute inpatient psychiatric program. Clinical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the client is hospitalized. The clinical record must by legible and include:

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is made on every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;
3. The complaint of others regarding the client, as well as the client's comments;
4. The psychiatric evaluation, including a medical history, which contains a record of mental status and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete neurological examination, when indicated, recorded at the time of the admitting physical examination;
6. ~~A biopsychosocial history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to appropriate treatment and discharge planning;~~
7. ~~A family assessment as described in 471 NAC 20-001. This document may be a part of the biopsychosocial assessment;~~
8. ~~8.~~6. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
9. ~~9.~~7. The client's treatment plan and treatment plan reviews;
10. ~~10.~~8. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;

32-003.01A Non-Residential Crisis Intervention: Non-residential crisis intervention services are provided to the family and client outside of a residential or institutional setting. This service includes supportive services therapy, brief assessment, and coordination services to help a family alleviate a crisis. These services must be directed by a supervising practitioner and psychiatric consultation must be readily available. Some assessment and intervention activities may be carried out by a clinical professional (see 471 NAC 32-001.04, item 2) who is acting within his/her scope of practice under the direction of a supervising practitioner.

The provider must have the capacity to respond to the family to unscheduled crisis intervention contacts 24 hours a day, seven days a week.

Providers of crisis intervention services must facilitate the referral to or provide the ~~pre-treatment assessment~~ Initial Diagnostic Interview. ~~(see 471 NAC 32-001.01)~~ if it has not already occurred.

32-003.01B Day Residential Crisis Intervention: Day residential crisis intervention services are provided to families when a safe and secure setting is needed to provide a therapeutic milieu for a child or adolescent for up to 23 hours and 59 minutes. This level is used when a brief stay in a secure setting will facilitate a de-escalation of the crisis. These services must be directed by a supervising practitioner with access to psychiatric consultation. The milieu and direct care interventions may be staffed by clinical professionals (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the ~~pre-treatment assessment~~ ~~(see 471 NAC 32-001.0~~ Initial Diagnostic Interview if it has not already occurred.

32-003.01C Residential Acute Crisis Intervention: Residential acute crisis intervention services are available to children and adolescents experiencing acute psychiatric crisis. The program provides crisis treatment and close supervision to stabilize a client and facilitate admission to the most appropriate treatment setting. These services must be directed under the cooperative supervision of a physician and other licensed practitioner of the healing arts. The milieu and direct care interventions may be staffed by clinical professionals (see 471 NAC 32-001.04) or technicians, under the direction of a supervising practitioner.

Providers of crisis intervention services must facilitate the referral to or provide the ~~pre-treatment assessment (see 471 NAC 32-001.01)~~ Initial Diagnostic Interview, if it has not already occurred.

32-004 Mental Health and Substance ~~Abuse~~ Use Disorder Day Treatment Services: Day treatment services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care is identified as part of a Substance Use Disorder Assessment. ~~a pre-treatment assessment (see 471 NAC 32-001.01).~~ These services are part of a continuum of care designed to prevent hospitalization or to facilitate the movement of the client in an acute psychiatric setting to a status in which the client is capable of functioning within the community with less frequent contact with the mental health or substance abuse provider.

Day treatment services must be community based, family centered, culturally competent, and developmentally appropriate.

Day treatment services must meet all requirements in 471 NAC 32-001.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-004.01 Covered Day Treatment Services: Day treatment programs shall provide the following mandatory services and at least two of the following optional services. Payment for both mandatory services and optional services is included in the rate for day treatment. Individual services to the client by a supervising practitioner that are not administrative in nature and are clinically necessary will be considered for payment when billed by the supervising practitioner. Providers shall not make any additional charges to the Department or to the client.

32-004.02B Service Standards:

1. The program must provide a minimum of three hours of services five days a week, which is considered a half day for billing purposes. Six hours a day of services is considered a full day of services. Services may not be prorated for under three (or six) hours of services, but may be for up to 12 hours of service.
2. A designated supervising practitioner must be responsible for the care provided in a day treatment program. The supervising practitioner must be present on a regularly-scheduled basis and must assume responsibility for all clients. If the supervising practitioner is present on a part-time basis, one of the clinical staff professionals acting within the scope of practice standards of the Nebraska Department of Health and Human Services, Division of Public Health (see 471 NAC 32-001.04) shall assume delegated professional responsibility for the program and must be present at all times when the program is providing services.
   Psychotherapy and substance abuse counseling services must be provided by clinical staff (see 471 NAC 32-001.04) who are operating within their scope of practice and under the direction of the supervising practitioner. The supervising practitioner's personal involvement must be documented in the client's clinical record.
3. A licensed psychologist, physician, or doctor of osteopathy may refer a client to a day treatment program, but all treatment must be prescribed and directed by the program supervising practitioner.
4. All treatment must be conducted under the direction of the supervising practitioner in charge of the program;
5. Admission Criteria: The following criteria must be met for a client's admission to a day treatment program:
   a. The client must have sufficient need for active treatment at the time of admission to justify the expenditure of the client's and program's time, energy, and resources;
   b. Of all reasonable options for active treatment available to the client, treatment in this program must be the best choice for expecting a reasonable improvement in the client's condition;
6. ~~Pre-Admission Assessment~~: Before the client is admitted to the program, a supervising practitioner ~~and other staff~~ shall complete an Initial Diagnostic Interview ~~a comprehensive pre-admission assessment~~ to validate the appropriateness of care. ~~This assessment is described in 471 NAC 32-001.01.~~
7. Treatment Plan: The program supervising practitioner shall determine the diagnosis and prescribe the treatment, including the modalities and the professional staff to be used. He/she must be responsible and accountable for all evaluations and treatment provided to the client.

The goals and objectives documented on the treatment plan must reflect the recommendations ~~included in the Pre-treatment Assessment and the integration of input~~ from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

32-005 Treatment Foster Care Services: Treatment foster care services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and ~~the pre-treatment assessment~~ an Initial Diagnostic Interview documents the need for continued care of this level. Treatment foster care occurs in a foster home when specially trained foster parents are available at all times to provide consistent behavior management programs, therapeutic interventions, and render services under the direction of a supervising practitioner. Treatment foster care services must be community-based, family focused, culturally competent, and developmentally appropriate. Treatment is provided within a family environment with services that focus on improving the client/family's adjustment emotionally, behaviorally, socially, and educationally. To be eligible to receive treatment in a treatment foster care program, the client must participate in a HEALTH CHECK (EPSDT).

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-005.01 Definitions: The following definitions and descriptions apply to treatment foster care services:

Agency Staff: Treatment foster care requires agency staff who are qualified, trained, and supported to implement the treatment model. Some treatment foster care initiatives have been undertaken in which one or a few staff with duties in other program areas assume responsibility for additional treatment foster care cases. Such arrangements tend to dilute the time, resources, and support available to the TFC Specialist and to the intensity and focus of the services provided. This does not constitute a true program of treatment foster care. A treatment foster care program must have an adequate number of staff to provide administration and direct services. See 471 NAC 32-001.04 for further staff requirements.

Children and Adolescents: Treatment foster care serves clients age 20 or younger whose special needs cannot be met in their own families and who require out-of-home care. In addition to providing treatment for specific problems or conditions, treatment foster care seeks to promote a permanent family living arrangement for the children and youth it serves.

d. Damages and liability: The treatment foster care program shall have a written plan concerning compensation for damages done to a treatment family's property by client/families placed in their care. This plan must be provided as part of their preservice orientation. The agency shall provide liability coverage or assist the treatment family in obtaining it. Treatment foster parents are required to show documentation of coverage for home/apartment, vehicle (if appropriate), property, and liability insurance in addition to any coverage provided by or through the treatment foster care program.

e. Legal advocacy: The treatment foster care program shall assist treatment parents in obtaining legal advocacy for matters associated with the proper performance of their role as treatment parents.

32-005.05 Covered Services for Treatment Foster Care: Payment for treatment foster care services under the Nebraska Medical Assistance Program is limited to payment for necessary treatment services for diagnosable conditions. ~~NMAP~~ Medicaid shall pay for treatment provided to ameliorate or correct the diagnosed condition. ~~NMAP~~ Medicaid does not make payment for care that is primarily chronic or custodial in nature.

32-005.05A Coverage Criteria: The Department covers treatment foster care services when the following criteria are met. The services must be -

1. Active Treatment, which must be -
   a. Treatment provided under a ~~Department approved treatment planning document~~ treatment plan developed by the multidisciplinary treatment team based on a thorough evaluation of the client's restorative needs and potentialities, including the developmental needs of clients age 20 or younger. The multidisciplinary treatment team includes the supervising practitioner, the TFC specialist, the TFC parent, and other staff as necessary. The treatment plan must be retained in the client's record.

      The treatment plan must be completed within 14 days of the client's admission to treatment foster care. The goals and objectives documented on the treatment plan must reflect the recommendations ~~included in the Pre-treatment Assessment and the integration of input~~ from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   b. Reasonably expected to improve the client's medical condition or to determine a diagnosis. The treatment must, at a minimum, be designed to correct or ameliorate the client's symptoms to facilitate the movement of the client to a less restrictive environment within a reasonable period of time.
   c. Consistent with the requirements listed in 471 NAC 32-001.06.

32-005.06 Intake Process: Treatment foster care services are available to clients age 20 or younger when the condition needing care has been identified during a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, the need for this level of care has been identified in the Initial Diagnostic Interview ~~pre-treatment assessment~~, and the client has a serious emotional disturbance as indicated by the following:

1. The youth must have a diagnosable condition under the current Diagnostics and Statistics Manual of the American Psychiatric Association, and that condition is seen as primarily responsible for the client's problems;
2. The condition must result in substantial functional limitations in two or more of the following areas:
   a. Self care at an appropriate developmental level;
   b. Perception and expressive language;
   c. Learning;
   d. Self-direction, including behavioral controls, decision-making judgment, and value systems; and
   e. Capacity for living in a family environment.

32-005.06A Intake Criteria: The following criteria must be met for a client's admission to a treatment foster care program:

1. The need for treatment foster care must be identified on an Initial Diagnostic Interview ~~a pre-treatment assessment (see 471 NAC 32-001.01)~~, based on the following criteria:
   a. The client must have sufficient need for active treatment at the time of intake to justify the expenditure of the client/family's and program's time, energy, and resources;
   b. Of all reasonable options for active treatment available to the client, active treatment in this program must be the best choice for expecting reasonable improvement in the client's condition;
2. The proposed or revised treatment plan must be the most efficient and appropriate use of the program to meet the client/family's particular needs;
3. The plan must address active and ongoing involvement of the family in care provision; and
4. The program is designed to meet the needs of clients age 20 and younger.

32-005.07 Preadmission Authorization and Continued Stay Review

32-005.07A Preadmission Authorization: For treatment foster care services to be covered by ~~NMAP~~ Medicaid, the need for admission to this level of care must be precertified by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice through an Initial Diagnostic Interview ~~and prior authorized through the Division of Medicaid and Long-Term Care~~.

32-005.07B Prior Authorization: Treatment Foster Care Services must be prior authorized by the Division of Medicaid and Long-Term Care or its designee.

32-006 Treatment Group Home

32-006.01 Introduction and Legal Basis: Treatment group home services are available to clients age 20 or younger when the client has participated in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for this level of care has been identified as part of ~~a pre-treatment assessment (see 32-001.01)~~.an Initial Diagnostic Interview. Treatment group homes are non-hospital based treatment services that are community-based, family-centered, and culturally competent.

Treatment group home services for children and adolescents covered by ~~NMAP~~ Medicaid include treatment group home services for children age 20 and younger who are eligible for Medicaid. The policy in this section also covers children age 18 or younger who are wards of the Department.

Treatment group home services must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within his/her scope of practice for reduction of physical or mental disability, to restore a recipient to a better level of functioning, and to facilitate discharge to a less restrictive level of care.

32-006.02 Treatment Group Home Services for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be developmentally appropriate, family-centered, culturally competent and community based. It must directly involve the immediate family in all phases of treatment and discharge planning. Family may include biological, step, foster, or adoptive parents, sibling or half sibling, and extended family members as appropriate.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

32-006.03G Annual Update Renewal: The treatment group home shall submit the following information with the provider application and agreement, and update/renewal the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and youth including:
   a. A complete description of how the family-centered requirement will be met, including a complete description of any home-based family therapy services;
   b. A complete description of how the community-based requirement will be met;
   c. A description of each available service;
   d. A list of treatment modalities available and the capacity for individualized treatment planning;
   e. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   f. A schedule covering the total number of hours that the program operates;
   g. The cost report; and
   h. The target population.
2. Confirmation that the staffing standards are met;
3. A copy of child caring agency licensure certificate; and
4. A copy of accreditation from JCAHO, CARF, COA, or AOA.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-006.04 Covered Services: Medicaid ~~NMAP~~ limits payment for treatment group home services to those services for medically necessary primary psychiatric diagnoses. Medicaid ~~NMAP~~ covers treatment group home services when the services are medically necessary and provide active treatment.

32-006.04A Pre-Admission Authorization: For treatment group home services to be covered by ~~NMAP~~ Medicaid, the admission must be recommended by a licensed practitioner of the healing arts who is able to diagnose and treat major mental illness within their scope of practice through an Initial Diagnostic Interview ~~a pre-treatment assessment as outlined in 471 NAC 32-001.01~~ and prior authorized through the Division of Medicaid and Long-Term Care or its designee. Consent for treatment for wards of the Department must be obtained from the case manager or supervisor.

2. Active treatment, which must be -
   a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The initial treatment plan must be developed within 14 days of the client's admission. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team, the parents and/or the parents' advocate, the referring agency and the child.

      The goals and objectives documented on the treatment plan must reflect the recommendations ~~included in the Pre-treatment Assessment and the integration of input~~ from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
   c. In compliance with 471 NAC 32-001.06, Active Treatment.
3. Medically necessary services, which must be an appropriate level of care based on the documented ~~pre-treatment assessment (see 471 NAC 32-001.01) including an~~ Initial Diagnostic Interview by the supervising practitioner either prior to admission or immediately following admission.

32-006.07 Documentation in the Client's Clinical Record: The treatment group home must maintain accurate records indicating the degree and intensity of the treatment provided to clients who receive services in the treatment group home facility. For treatment group home services, clinical records must stress the clinical components of the care, including history of findings and treatment provided for the condition for which the client is in the facility. The record must include the requirements stated in 471 NAC 32-001.05, and -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every patient at the time of admission and includes the diagnoses of intercurrent diseases as well as the diagnoses;
3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;
4. The ~~pre-treatment assessment (see 471 NAC 32-001.01), including a~~ medical/psychiatric history, which contains a record of the initial diagnostic interview and notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. Complete psychological evaluation when indicated;
6. Complete neurological examination, when indicated;

7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment, and transition and discharge planning.
8. A thorough family assessment;
9. Reports of consultations, electroencephalograms, dental records, and special studies;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities.
12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge.
13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and
14. The client's response to therapeutic leave days recommended by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

All documents from the client's clinical record submitted to the Department must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

32-006.08 Utilization Review: All facilities must provide utilization review.

32-006.09 Documentation for Claims: The following documentation is required for all claims for treatment group home services. This requirement may be waived at the Department's discretion. The facility will be notified in writing if that occurs:

1. ~~Pre-treatment assessment (biopsychosocial assessment and initial diagnostic interview)~~ Initial Diagnostic Interview;
2. The treatment plan;
3. Orders by the supervising practitioner; and
4. Progress notes for all disciplines.

All claims are subject to utilization review by the Department prior to payment.

32-006.09A Exception: Additional documentation from the client's clinical record may be requested by the Department prior to considering authorization of payment.

32-007 Residential Treatment Services for Children/Adolescents

32-007.01 Introduction: Residential treatment services are available to clients age 20 or younger when the client participates in a HEALTH CHECK (EPSDT) screen, the treatment is clinically necessary, and the need for care at this level has been identified on the ~~pre-treatment assessment (see 471 NAC 32-001.01).~~ Initial Diagnostic Interview.

Residential treatment services must be family-centered, culturally competent, community based, and developmentally appropriate.

Providers must encourage family members to be involved in the assessment of the client, the development of the treatment plan, and all aspects of the client's treatment unless prohibited by the client, through legal action, or because of federal confidentiality laws.

Providers must be available to schedule meetings and sessions in a flexible manner to accommodate and work with a family's schedule. This includes the ability to schedule sessions at a variety of times including weekends or evenings.

The provider must document their attempts to involve the family in treatment plan development and treatment plan reviews. A variety of communication means should be considered. These may include, but should not be limited to, including the family via conference telephone calls, using registered letters to notify the family of meetings, and scheduling meetings in the evening and on weekends.

Residential treatment services for children covered by ~~NMAP~~ Medicaid include residential treatment for children age 20 and younger who are eligible for Medicaid. These regulations also cover children age 18 or younger who are wards of the Department.

Residential treatment services must be provided under the direction of a supervising practitioner as designated in 471 NAC 32-001.~~02A~~.06

32-007.02 Residential Treatment for Children: The Department's philosophy is that all care provided to clients must be provided at the least restrictive and most appropriate level of care. Care must be family-centered, community-based, culturally competent, and developmentally appropriate. ~~NMAP~~ Medicaid will cover more restrictive levels of care only when all other resources have been explored and deemed to be inappropriate. If hospital-based inpatient care is deemed appropriate, see 471 NAC 32-008.

Residential treatment center services are clinically necessary services provided to a client who requires professional care and highly structured 24-hour awake care at a greater intensity than that available at the treatment group home and foster home levels.

8. Allow for more than one type of activity to be scheduled at one time allowing for specialized and individualized treatment planning;
9. Provide a progress report to the referring agency, and the parents or legal guardian every month for the purpose of service coordination. For wards of the Department, monthly reports must be provided to the Division of Children and Family Services case manager. The documentation from the Monthly Treatment Plan review may serve this purpose;
10. The services of specialists in the fields of medicine, psychiatry, psychology, and education must be used as needed.

32-007.03G Annual Update/Renewal: The residential treatment center shall submit the following information with the provider application and agreement, and update/renewal the information annually to coincide with submission of the cost report:

1. A written overview of the program's philosophy and objectives of treating children and adolescents including:
   a. A description of each available service;
   b. A list of treatment modalities available and the capacity for individualized treatment planning;
   c. A statement of the qualification, education, and experience of each staff member providing treatment and the therapy service each provides;
   d. A schedule covering the total number of hours that the program operates;
   e. The cost report; and
   f. The target population.
2. Confirmation that the staffing standards in 471 NAC 32-007.03E are met;
3. Copy of child caring agency licensure certificate; and
4. Copy of accreditation certificate.

The Division of Medicaid and Long-Term Care or its designee may request this information on an intermittent basis and the provider must comply by promptly supplying the requested information.

32-007.04 Covered Services: Medicaid ~~NMAP~~ limits payment for residential treatment services to those services for medically necessary to treat primary diagnoses. Medicaid ~~NMAP~~ covers residential services as delineated in 471 NAC 32-007 when the services are medically necessary and provide active treatment.

32-007.04A Pre-Admission Authorization: For residential treatment center services to be covered by ~~NMAP~~ Medicaid, the need for admission to this level of care must be determined by a supervising practitioner through a thorough ~~pre-treatment assessment (see 471 NAC 32-001.01)~~ Initial Diagnostic Interview and prior authorized through the Medicaid Division or its designee. For wards of the Department, consent for treatment for wards of the Department must be obtained from the Department case manager or supervisor. See 471 NAC 32-~~001.~~ 006.01, 32-006.03F, 32-006.04A, 32-006.05B

32-007.06 Individual Treatment: To be covered by NMAP, individual treatment services must include -

1. Program philosophy: Residential treatment facilities must provide intensive family-centered, community-based, developmentally appropriate services under the direction of a supervising practitioner.
   a. These services must be able to meet the special needs of families, including the "identified client" in the treatment facility. Families must be involved in treatment and discharge planning. For wards of the Department, the case manager must also be involved in treatment and discharge planning.
   b. The program intensity must be such that direct care staff, the client in treatment, and/or the client's family have access to professional staff on an "as needed" basis, determined by the client's condition.
2. Active treatment, which must be -
   a. Treatment provided under a multi-disciplinary treatment plan reviewed and approved by the supervising practitioner. This plan will be developed within 14 days of admission by a multi-disciplinary team of professional staff members. The treatment plan must be for a primary psychiatric diagnosis and must be based on a thorough evaluation of the client's restorative needs and the client's potential. The treatment plan must be reviewed at least every 30 days by the multi-disciplinary team.
   The goals and objectives documented on the treatment plan must reflect the recommendations ~~included in the Pre-treatment Assessment and the integration of input~~ from the Initial Diagnostic Interview, the supervising practitioner and the therapist. The treatment interventions provided must reflect these recommendations, goals, and objectives. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.
   b. In compliance with 471 NAC 32-001.07, Treatment Planning; and
   c. In compliance with 471 NAC 32-001.06, Active Treatment.
3. Medically necessary services, which must be an appropriate level of care based on documented ~~pre-treatment assessment (see 471 NAC 32-001.01)~~ Initial Diagnostic Interview including a comprehensive diagnostic workup and supervising practitioner-ordered treatment.

32-007.07 Documentation in the Client's Clinical Record: The center must maintain accurate clinical records indicating the degree and intensity of the treatment provided to clients who receive services in the residential treatment facility. For residential services, clinical records must stress the treatment intervention components of the clinical record, including history of findings and treatment provided for the psychiatric condition for which the client is in the facility. The clinical record must include the requirements stated in 471 NAC 32-001.05 and -

1. The identification data, including the client's legal status (i.e., voluntary admission, Board of Mental Health commitment, court mandated);
2. A provisional or admitting diagnosis which is determined for every client at the time of admission and includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;

3. The statements of others regarding the client's problems and needs, as well as the client's statement of their problems and needs;
4. The ~~pre-treatment assessment~~, Initial Diagnostic Interview, including a medical/psychiatric history, which contains a record of mental status and notes the onset of illness/problems, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the client's strengths in a descriptive, not interpretative, fashion;
5. A complete psychological evaluation;
6. A complete neurological examination, when indicated;
7. A social history sufficient to provide data on the client's relevant past history, present situation, social support system, community resource contacts, and other information relevant to good treatment and discharge planning;
8. A thorough family assessment;
9. Reports of consultations, psychological evaluations, electroencephalograms, dental records, and special studies;
10. The treatment received by the client, which is documented in a manner and with a frequency to ensure that all active therapeutic efforts, such as individual, group, and family psychotherapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, nursing care, and other therapeutic interventions, are included;
11. Progress notes must be recorded by all professional staff and, when appropriate, others significantly involved in active treatment modalities, following each contact. The frequency is determined by the individual treatment plan and the condition of the client, but should be recorded at least daily. Progress notes must contain a concise assessment of the client's progress and recommendations for revising the treatment plan as indicated by the client's condition. Child care workers must maintain 24-hour documentation of a client's whereabouts and activities;
12. The transition plan and discharge summary, including a summary of the client's and family's treatment, recommendations for appropriate services concerning follow-up, and a brief summary of the client's condition on discharge;
13. The psychiatric diagnosis contained in the final diagnosis written in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual; and
14. The client's response to therapeutic leave days prescribed by the supervising practitioner under the treatment plan. The client's, family's, or guardian's response to time spent outside the facility must be entered in the client's clinical record.

All documents from the client's medical record submitted to the Division of Medicaid and Long-Term Care must contain sufficient information for identification (i.e., client's name, date of service, provider's name).

35-004 Covered Services: ~~NMAP~~ Medicaid covers the following rehabilitative psychiatric services under the rules and regulations of this chapter.

1. Community Support;
2. Day Rehabilitation;
3. Psychiatric Residential rehabilitation.

For the purposes of meeting the requirements of 471 NAC 35-002, programs certified by the Department of Health and Human Services under 204 NAC 5 (effective date December 19, 1994) as Residential Support and/or Service Coordination providers shall be considered to be certified as Community Support providers.

35-004.01 Community Support: The Community Support program is designed to:

1. Provide/develop the necessary services and supports to enable clients to reside in the community;
2. Maximize the client's community participation, community and daily living skills, and quality of life;
3. Facilitate communication and coordination between mental health rehabilitation providers that serve the same client; and
4. Decrease the frequency and duration of hospitalization.

Community support shall provide client advocacy, ensure~~s~~ continuity of care, support~~s~~ clients in time of crisis, provide/procure skill training, ensure~~s~~ the acquisition of necessary resources, to assist clients with spend downs and other financial insurance coverage programs and assist~~s~~ the client in achieving community/social integration. The community support program shall provide a clear focus of accountability for meeting the client's needs within the resources available in the community. The role(s) of the community support provider may vary based on client's needs. Community support is a service in which the client's contact occurs outside the program offices in community locations consistent with the individual client choice/need. Community support is frequently provided in the home and is not facility or office-based. Ninety-day treatment, rehabilitation and recovery team meetings are not considered to be a community support service. The frequency of contact between the community support provider and the client is individualized and adjusted in accordance with the needs of the client.

Prior to admission to a community support program, ~~a client shall have a comprehensive Pretreatment Assessment. The~~ an Initial Diagnostic Interview ~~(Part II of the PTA)~~ shall be completed by an independently licensed practitioner (psychiatrist, psychologist, or LIMHP). The purpose of this assessment is to determine/verify the presence of a severe and persistent mental illness which requires psychiatric rehabilitation services. The document must include the need of the specific rehabilitation services necessary to meet the treatment and recovery goals of the client.

Community Support is a separate and distinct service, and may not be provided as a component of other Rehabilitative Psychiatric Services or Mental Health Outpatient Services. Agencies that provide more than one level of rehabilitative psychiatric or Mental Health Outpatient service shall have staff dedicated to the Community Support program. These Community Support staff shall not provide any other rehabilitative psychiatric or treatment service to the client.

35-004.01A Program Components: The Community Support program shall –

1. Facilitate communication and coordination among the mental health rehabilitation providers serving the client;
2. ~~Ensure that if a Pretreatment Assessment was completed 12 months or more prior to admission, the licensed mental health practitioner shall review and update the Biopsychosocial Assessment (Part I of the Pretreatment Assessment) within 30 days of admission of the client into the program. The assessments shall identify needed services and resources for each client;~~ Ensure that the client has a diagnosis of severe and persistent mental illness, as exhibited by the completion of an Initial Diagnostic Interview, no more than 12 months prior to admission to Community Support. The Initial Diagnostic Interview must identify the need for Community Support and outline the needed services and resources for the client.
3. Ensure completion of a strength-based needs assessment which may include skills inventories, interviews and other tools to develop treatment and rehabilitation plans which must be completed within 30 days of admission by the rehabilitation team or team members.
4. Ensure the completion of an Individual Treatment, Rehabilitation, and Recovery Plan for each client served. The Individual Treatment, Rehabilitation, and Recovery Plan shall be completed within 30 days following the admission of the client and reviewed and updated every 90 days or as often as clinically necessary thereafter while receiving services. The Individual Treatment, Rehabilitation, and Recovery Plan shall be based on the results of comprehensive assessments and is developed with the client's involvement and through an interdisciplinary team process. The Individual Treatment, Rehabilitation, and Recovery Plan shall include methods and interventions to address: activities of daily living, community living skills, budgeting, education, independent living skills, social skills, interpersonal skills, psychiatric emergency/relapse, medication management including recognition of signs of relapse and control of symptoms, mental health services, physical health care, vocational/educational: services, resource acquisition, and other related areas as necessary for successful living in the community.
5. Ensure the Individual Treatment, Rehabilitation, and Recovery Plan that encompasses the supportive/rehabilitative interventions that will be directly provided by the Community Support Program;
6. Identify the provision of services/interventions identified in the Individual Treatment, Rehabilitation, and Recovery Plan as the responsibility of other rehabilitative service providers;
7. Develop and implement strategies to assist the client in becoming engaged and remaining engaged in medically necessary mental health treatment and psychiatric rehabilitation services;
8. Provide service coordination and case management activities, including coordination or assistance in accessing medical, social, education, housing, transportation or other appropriate support services as well as linkage to other community services identified in the Individual Treatment, Rehabilitation, and Recovery Plan.
9. Facilitate communication between the treatment and rehabilitation providers and with the primary care physician/psychiatrist serving the client.
10. Monitor client progress of the services being received and participate in the revision of the Individual Treatment, Rehabilitation, and Recovery Plan as needed or at the request of the client;

Clinical records shall be maintained at the provider's headquarters. Records shall be kept in a locked file when not in use. For purposes of confidentiality, disclosure of treatment information is subject to all the provisions of applicable State and Federal laws. The client's clinical record shall be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason shall be documented in the clinical record and reviewed periodically.

35-004.04A The clinical record shall include, at a minimum:

1. Client identifying data, including demographic information and the client's legal status;
2. Assessment and Evaluations;
   a. ~~Pretreatment Assessment~~ Initial Diagnostic Interview completed prior to admission;
   b. Strength-based needs assessment;
   c. Other appropriate assessments.
3. Treatment and Recovery Plan and updates to plans;
4. Documentation of review of Client Rights with the client;
5. A chronological record of all services provided to the client. Each entry shall include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service (beginning and end time), the place of the service, and the staff member's identity and legible signature, (name and title);
6. Documentation of the involvement of family and significant others;
7. Documentation of treatment and recovery services and discharge planning;
8. A chronological listing of the medications prescribed (including dosages and schedule) for the client and the client's response to the medication;
9. Documentation of coordination with other services and treatment providers;
10. Discharge summaries from previous levels of care;
11. Discharge summary (when appropriate); and
12. Any clinical documentation requirements identified in the specific service.

35-004.05 Provider Participation: To participate as a Medicaid provider of psychiatric community support, the provider shall be enrolled as a provider of services according to Medicaid regulations. Providers shall contact the Medicaid Managed Care entity to credential into its network. The provider shall provide updates to the program information and staffing as necessary. The provider shall sign an agreement at the time of enrollment that states the provider will submit initial and annual cost information to Medicaid as a part of the enrollment. The cost information shall be updated upon request.

Community support providers shall be appropriately licensed when licensure is required to provide the service and the program shall have acquired national accreditation in JCAHO, CARF or COA as a condition for enrollment as a participating provider. Accreditation shall be maintained throughout the Medicaid participation period.

35-014.01A Assessments: The following assessments must be completed:

1. A comprehensive mental health and substance ~~abuse~~ use disorder assessments, by an independently licensed mental health practitioner must occur prior to admission.
2. Following admission and within 24 hours of stay, an assessment by the program's psychiatrist must be completed;
3. A history and physical must be completed by a physician or Advanced Practice Registered Nurse (APRN) within 24 hours of admission or one must be completed within 60 days of admission and available in the clinical record;
4. ~~Comprehensive strength-based biopsychosocial assessment must be completed within 14 days of admission to assess the client according to the requirements described in 471 NAC 35-014.01A1;~~
5. A nursing assessment must be completed by a Registered Nurse within 24 hours of admission; and
6. A functional assessment must be completed initially upon admission and annually with continued stay at this level of service.

~~35-014.01A1 Components of the Biopsychosocial Assessment: The biopsychosocial assessment must be completed within the timeframe specified in the Secure Psychiatric Residential Rehabilitation program's policies and procedures, however, no more than 14 days after admission. Components 1 through 9 of this assessment must be completed by a licensed mental health practitioner. Clinical impressions, including diagnosis and recommendations for treatment and rehabilitation, must be completed by the program's psychiatrist. The assessment must be in narrative form and include the following components:~~

~~1. Client name, Medicaid identification number, emergency contact (name, relationship, and contact information), and other information of the client that is relevant;~~
~~2. Provider demographics including: provider name, address, phone number, fax number, and e-mail address, and other contact information;~~
~~3. Presenting problem, primary complaint including:~~
~~a. Signs, symptoms, problems and dysfunctions relating to mental illness;~~
~~b. Reason for referral to Secure Psychiatric Residential Rehabilitation services and referral source;~~
~~c. Name and title of the referral professional (MD, psychologist, APRN, or LIMHP);~~
~~d. Presenting problem from the client's and provider's perspective; and~~
~~e. External leverage to seek evaluation (courts, family and other);~~
~~4. Medical History:~~
~~a. Dental history and current needs;~~
~~b. Current medication list;~~
~~c. Compliance with medication (historical and current);~~
~~d. Current primary care physician (name and contact information);~~
~~e. Date of last physical exam and physician providing that assessment;~~
~~f. Recent hospitalizations; and~~
~~g. Major health concerns (such as STD's, HIV, Tuberculosis, Hepatitis, and pregnancy);~~
~~5. Employment/Education/Military History:~~

a. History of employment;
b. Educational history;
c. Military involvement; and
d. Strengths;

6. Alcohol/Drug History:
   a. Primary drug(s) of choice;
   b. Amount, frequency and duration of use;
   c. Prior treatment(s), location and length of stay;
   d. Current compliance with relapse prevention plan;
   e. Periods of abstinence (supports needed);
   f. Tolerance level/withdrawal/history of complications from withdrawal;
   g. Prior alcohol/drug evaluations/recommendations, including scores and results of screening tools;
   h. Family history of alcohol/drug use; and
   i. Other addictive behaviors (gambling, food, etc.);
7. Legal History (Information from Criminal Justice System):
   a. Criminal history and consequences of criminal involvement;
   b. Connection to alcohol/drug use;
   c. Current legal charges/disposition of charges;
8. Family/Social/Peer:
   a. Family members (age and level of involvement with client);
   b. Adult or minor children (names, ages and level of involvement);
   c. Parenting knowledge or skill level, history of system involvement (courts);
   d. Social supports utilized by client (previous and current);
   e. Housing (ability to maintain housing, type of current housing, need for assistance);
   f. Recreational activities (client's preference);
   g. Collateral information;
   h. Client strengths as perceived by client and collateral contacts;
9. Psychiatric/Behavioral History:
   a. Current diagnosis(s);
   b. Previous treatment(s) and outcome(s) of treatment(s);
   c. Current mental health and substance abuse providers and treatment currently provided;
   d. Current psychiatric medication list;
   e. Compliance with medication (historical and current);
   f. History of self harm or threats to harm others;
   g. Board of mental health commitments (reason and dates of commitment);
   h. Abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault; and
   i. Trauma (serious accident/injury, sexual assault/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters (tornado, earthquakes), sanctuary trauma (trauma while institutionalized), prostitution/sex trafficking;

~~10. Clinical Impressions: (must be completed by the licensed psychiatrist supervising the program and must be consistent with the psychiatrist's initial diagnostic interview):~~
~~a. Information that supports/justifies the recommendations; and~~
~~b. DSM diagnosis, Axis 1-5;~~
~~11. Recommendations by the program's psychiatrist:~~
~~a. Primary/ideal level of care;~~
~~b. Available level of care/barriers to ideal level of care; and~~
~~c. Client/family's response to recommendations;~~
~~12. Signature of psychiatrist and the licensed mental health practitioner completing the assessment; and~~
~~13. Date of signature.~~

35-014.01B Individual Treatment, Rehabilitation, and Recovery Planning: An initial Individual Treatment, Rehabilitation, and Recovery Plan must be completed within 24 hours of admission. Secure Psychiatric Residential Rehabilitation Service providers must develop an individual treatment, rehabilitation, and recovery plan with the client within 30 days following admission to the program. The plan must include substance abuse issues. The client's family and/or guardian must be included in all assessment and treatment, rehabilitation, and recovery planning. The provider must make every effort to be available and responsive to the client's family and/or guardian to assist their involvement in the client's recovery. The plan must be reviewed and revised with the client, discussing and documenting the discharge plan a minimum of every 7 days according the following requirements.

35-014.01B1 Individual Treatment, Rehabilitation, and Recovery Plan: The master individual treatment, rehabilitation, and recovery plan must be based upon a comprehensive assessment and completed within 30 days of admission. This plan must:

1. Be oriented to the principles of recovery and meaningful client participation;
2. Apply the principles of recovery – to include meaningful client participation, and a life in the community of the client's choosing;
3. Incorporate and be consistent with best practices;
4. Include the client's individualized goals and expected outcomes;
5. Contain prioritized objectives that are measurable and time-limited;
6. Describe therapeutic interventions to be used in achieving the goals and objectives that are recovery-oriented, trauma-informed, and strength-based;
7. Identify staff responsible for implementing the therapeutic interventions;
8. Specify the planned frequency and duration of each therapeutic method;
9. Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care and reviewed weekly;
10. Include a plan developed with the client that includes strategies to avoid crisis or admission to a higher level of care using principles of recovery and wellness;
11. Include the signature of the client and/or parent/guardian;
12. Include health care proxy and trauma safety form when available and with client's consent;

35-014.02A3 Responsibilities of the Mental Health Practitioner: The mental health practitioner must:

1. Complete a ~~biopsychosocial~~ comprehensive assessment within 14 days of admission when this responsibility is delegated by the program director;
2. Participate in the development of the individual treatment, rehabilitation, and recovery plan and the updates;
3. Provide individual, group and family psychotherapy according to the client's individual treatment, rehabilitation, and recovery plan;
4. Communicate with the Program Director and psychiatrist regarding the clinical needs of the client as necessary;
5. Monitor, supervise, and oversee the program's daily treatment and activities in the absence of the Program Director as assigned by the Program Director;
6. Assist with aggressive discharge planning; and
7. Maintain a maximum staffing ratio of 1 to 8 clients.

35-014.02A4 Direct Care Staff: The Secure Psychiatric Residential Rehabilitation Program must employ direct care staff who:

1. Are on site and available to the clients at a ratio of one staff per four clients during awake hours and a minimum of one awake direct care per staff per six clients during overnight hours;
2. Staff to client ratios must be enhanced to meet client need as necessary.
3. Direct Care staff having a bachelor's degree in psychology, sociology or related human services field but two years of course work in the human services field and two years of experience/training or two years of lived recovery experience is acceptable. Each staff must have demonstrated skills and competency in treatment with individuals with mental health diagnosis.

35-014.03 Discharge Planning: Throughout a client's care and whenever the client is transitioned from one level of care to another, discharge planning must occur in advance of this discharge. It must include the client's and client's family/legal guardian's input and be documented in the client's clinical record. The plan must be recovery-oriented, trauma-informed, and strength-based.

Providers must meet the following standards regarding recovery and discharge planning:

1. Discharge planning must begin on admission to the service with input and participation of the client and client's family/guardian;
2. Discharge planning must include the client and family input and be consistent with the goals and objectives identified in the individual treatment, rehabilitation, and recovery plan and clearly documented in the clinical record;
3. Discharge planning must address the client's needs for ongoing services to maintain the gains and to continue as normal functioning as possible following discharge. A crisis/relapse/safety plan must be in place;

4. Providers must make or facilitate referrals and applications to the next level of care and/or community support services, such as use of medications, housing, employment, transportation, and social connections;
5. Providers must arrange for the prompt transfer of clinical records and information to ensure continuity of care; and
6. A written discharge summary must be provided as part of the clinical record. It must identify the readiness for discharge and contain the signature of a fully licensed clinician and date of signature and must identify a summary of the services provided.

35-014.04 Clinical Documentation: Secure Psychiatric Residential Rehabilitation service providers must maintain a clinical record that is confidential, complete, accurate, and that contains up-to-date information relevant to the client's care and services. The record must sufficiently document comprehensive assessments; individual treatment, rehabilitation, and recovery plans; and plan reviews. The clinical record must document client contacts describing the nature and extent of the services provided, so that a clinician unfamiliar with the service is able to identify the client's service needs and services received. The documentation must reflect the rehabilitative services provided; that the care is consistent with the goals in the individual treatment, rehabilitation, and recovery plan; and that the care is based upon the comprehensive assessment. The absence of appropriate, legible, complete records may result in the recoupment of previous payments for services. Each entry must identify the date, beginning and ending time spent providing the service and location of service, and identify by name and title the staff person entering the information.

Clinical records must be maintained at the client's primary rehabilitation site. Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of rehabilitation information is subject to all the provisions of applicable State and Federal laws. The client's clinical record must be available for review by the client (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

35-014.05 The clinical record must include, at a minimum:

1. Client identifying data, including demographic information and the client's legal status;
2. Assessment and Evaluations:
   a. Psychiatric assessment, including the name of the clinician and the date of the assessment;
   b. Comprehensive ~~Biopsychosocial~~ Assessment; and
   c. Other related assessments;
3. The client's diagnostic formulation (including all five axes);
4. The Individual Treatment, Rehabilitation, and Recovery Plan and updates to plans;
5. Documentation of review of client rights with the client;
6. A chronological record of all services provided to the client. Each entry must include the date the intervention was performed, the duration of the intervention (beginning and ending time), the place of the service, and the staff member's identity and legible signature (name and title);

35-017 Community Support: Substance Abuse Community Support is a rehabilitative and supportive service for individuals with primary Axis I Diagnosis of Substance Dependence. Community Support Interventions provide direct rehabilitation and support services to individuals in the community to assist the individual in maintaining abstinence, stabilizing community living, and preventing exacerbation of symptoms and admissions to more restrictive levels of care. This service is not available for individuals who are also receiving level III or greater substance abuse treatment services. Services are based upon medical necessity as identified in the client's treatment and recovery plan and shall be provided in 15-minute increments.

35-017.01 Program Components: The Community Support Program shall:

1. Facilitate communication and coordination among all health care professionals providing services to the client;
2. Ensure completion of a strength-based needs assessment completion within 30 days of admission by the rehabilitation team or team member;
3. Develop and implement strategies to encourage the individual to become engaged and remain engaged in necessary substance use/abuse and mental health treatment services as recommended and included in the treatment/recovery plan;
4. Have access to the comprehensive substance use disorder ~~abuse~~ assessment ~~including a biopsychosocial assessment~~ conducted by ~~a fully~~ an independently licensed practitioner practicing within his/her scope updated within 30 days of admission into the program;
5. Participate with and report to the treatment and recovery team on the individual's progress and response to community support intervention in areas of relapse prevention of substance use/abuse and application of education and skills in the recovery environment;
6. Review and update the treatment and recovery plan and discharge plan with the individual and other approved family supports every 90 days or more often as clinically necessary;
7. Coordinate with the providers of mental health when the client has a co-occurring diagnosis and receiving mental health services by a licensed practitioner either located in the agency or in a separate program;
8. Assist in facilitating the transfer to and the transition to other levels of treatment service;
9. Assist in the development, evaluation, and update in a crisis and relapse plan with the client;
10. Provide contact as needed with other providers, client family members and other significant individuals in the client's life to facilitate communication necessary to support the individual in maintaining community living;
11. When prescribed, monitor medication compliance and report compliance issues as necessary;
12. Assist the client with all health insurance issues; and
13. Assist in the discharge plan for the client and support development of community-based resources.